APPENDIX 10
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION CLOZAPINE ATTACHMENT (PA/CZA)

The information contained on this prior authorization clozapine attachment will be used to make a decision about appropriateness and length of time which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

Questions regarding the completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Clozapine Attachment (PA/CZA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in years (e.g., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN NAME
Enter the name of the physician who is prescribing the Clozapine. The prescribing physician is that physician who is treating the patient.

ELEMENT 7 - PRESCRIBING PHYSICIAN NUMBER
Enter the nine-character DEA number of the prescribing physician.

ELEMENT 8 - PRESCRIBING PHYSICIAN TELEPHONE NUMBER
Enter the telephone number, including area code, of the prescribing physician.

DOCUMENTATION:

Copies of written and signed documentation may be substituted only if they provide the same information as that requested on the PA/CZA and are dated within two months of receipt at EDS.

Section I

1. Must be completed by a physician. Indicate diagnoses by code and description on all five axes from the current DSM.

2. On the initial request, this information should be historical and include justification for Clozapine treatment. Provider may attach copies of evaluations, treatment history, etc., if they support all the information requested, but these copies should not substitute for brief summary requested.

   On subsequent requests, it should be information updated since the previous request.

Section II
Previous Neuroleptic Medication should include all neuroleptic medication used during the past 10 years, or longer if the failed treatment occurred more than 10 years ago. Since Clozapine is recommended only after the failure of at least two neuroleptic medications, this section must be completed on the initial request. It must document the failures of two neuroleptic medications. This area does not need to be completed on subsequent requests. (Attach additional pages if necessary.)

Section III
Include hospital days for psychiatric disorders within the past six months, three years, and five years on the initial request. Include updated information on subsequent requests.

Record the number of hospitalizations that preceded those listed above.

Section IV Brief Psychiatric Rating Scale (BPRS)
Please complete the 24-point Brief Psychiatric Rating Scale (BPRS). The BPRS must be done in person by a clinician trained to assess mental status and must be dated within two months of receipt at EDS.

Section V
Document the prescribing physician's qualifications for prescribing neuroleptic medication. This area does not need to be completed on subsequent requests if the prescriber does not change. Papers showing credentials may be substituted.

Prescription
Attach a copy of the physician's prescription to the form. The prescription must be signed and dated within two months of receipt at EDS and should be of standard format (e.g., dosage and duration.)

Signature
The form must be dated and signed by the prescribing (treating) physician.

Section VI Additional Information
The information requested below is not used in adjudicating the prior authorization but is required for a long-term study of Clozapine. All information must be supplied on each request.

A. Social Status

   Please complete questions 1 through 6.

B. Medication Administration - Please answer questions 1 through 3. While these functions are the responsibility of the prescribing physician, this information offers some assurance that the management recommended by the manufacturer is being followed.

C. Current Medications - The list should include all drugs the patient is using currently or has used during the past month. A medication order record may be substituted.

D. Non-Medical Treatment - On the initial request, describe non-medical services the individual has received. Update information as necessary on subsequent requests.